Louisiana Department of Health and Hospitals

Authorization to Release or Obtain Health Information (including paper, oral and electronic information)

Name:	Request Date:
Mailing Address:	Date of Birth:
City/State/Zip:	Medicaid # or Social Security #:

I authorize:

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Telephone Number:_____

❒ **RELEASE Information TO** **or** ❒ **OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship: _____ Telephone Number:_____

The **Purpose of this Authorization** is indicated in the box(es) below. *(Place an "X" in the box(es) that apply.)*

❒ Further Medical Care ❒ Personal ❒ Legal Investigation or Action

❒ Changing Physicians ❒ Research related treatment

❒ Creating health information for disclosure to a third party.

❒ Other: (Specify)_____

I authorize the release of the following protected health information.
(Place an "X"in the box(es) that apply to the information you want released or you want to obtain.)

❒ Entire Record ❒ Medical History, Examination, Reports ❒ Surgical Reports ❒ Treatment or Tests
❒ Prescriptions ❒ Immunizations ❒ Hospital Records including Reports ❒ Laboratory Reports
❒ X-ray Reports ❒ MR/DD Records ❒ Other: _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.

❒ Alcoholism ❒ Drug Abuse ❒ Mental Health ❒Vocational Rehabilitation ❒ HIV (AIDS)
❒ Sexually Transmitted Diseases ❒ Genetics ❒ Psychotherapy Notes
❒ Other_____

This authorization shall expire on _____ (date or event) and is needed for the period beginning _____ and ending _____.

I understand that if I do not specify an expiration date, this authorization will expire six (6) months from the date on which it was signed. I acknowledge that I have read both pages 1 and 2 of this form. I authorize a copy (including electronic or faxed copy) of this form for the disclosure of the information described above.

_____ _____
Signature of Individual or Personal Representative authorized by law Date

Please submit medical information to:

Agency Representative	**Title**	**Date**
Telephone	**Fax**	**Email**

Important Information about Authorization

We may need your authorization to use, disclose or obtain your health information for some of our services.

You do not have to sign this form. If you agree to sign this authorization to release or obtain information you will be given a copy of the signed form, upon request

A separate signed authorization form is required for the use and disclosure of health information for:

- ✓ Psychotherapy notes
- ✓ Employment-related determinations by an employer
- ✓ Research purposes unrelated to your treatment

When required by law or policy, DHH may only obtain, use and disclose your health information if the required written authorization includes all the required elements of a valid authorization.

- ✓ An authorization is voluntary. You will not be required to sign an authorization as a condition of receiving treatment services or payment for health care services. If your authorization is required by law or policy, DHH will use and disclose your health information as you have authorized on the signed authorization form.

- ✓ You may be required to sign an authorization before receiving research-related treatment.

- ✓ You may be required to sign an authorization form for the purpose of creating protected health information for disclosure to a third party. *Example:* In a juvenile court proceeding where a parent is required to obtain a psychological evaluation on their minor child by DHH, the parent may be required to sign an authorization to release the evaluation report (but not the psychotherapy notes) to DHH.

- ✓ You may cancel an authorization in writing at any time. DHH can not take back any uses or disclosures already made before an authorization was cancelled.

- ✓ Information used or disclosed by this authorization may be re-disclosed by the recipient and will no longer be protected by DHH privacy policies.

Your right to file a privacy complaint

You may contact the Privacy Office listed below if you want to file a complaint or to report a problem about how DHH has used or disclosed information about you. Your benefits will not be affected by any complaints you make. DHH cannot punish or retaliate against you for filing a complaint, cooperating in any investigation, or refusing to agree to something that you believe to be unlawful. Your Privacy office contact is: State of Louisiana, Department of Health and Hospitals, Office of Secretary, *Privacy Office, P.O. Box 629, Baton Rouge, LA 70821-0629*. Phone: 1-877-559-9664. E-mail: privacy-bhsf@la.gov